

# MEDICATION OCCURRENCES

## Department of Mental Retardation

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v.0627

\*Individual: First Name:

\*Last Name:

(\* = *Required Field*)

\*(1) Reporting Provider:

\*(2) Responsible Site:

\*(3) Responsible Site Phone Number:

\*(4) Staff Responsible for MOR Follow-up:

(4A) First Name:

(4B) Last Name:

\*(5) What Happened? Omission

\*(6) Date of Discovery:

\* (7) Time:

\*(8) Date of Medication Occurrence:

\* (9) Time:

\*(10) Did the Medication Occurrence Happen Over Multiple Consecutive Administrations? ☐ YES ☐ NO

\*(11) If Yes in #10, over what number of doses did the medication occurrence happen?

\*(12) Staff Position of Person Giving Medication: MAP Certified Staff -Direct Care (from Dictionary #1)

\*(13) Medication Occurrence: Misread Label (from Dictionary #2)

\*(14) MAP Consultant's Title: ☐ Registered Nurse ☐ Registered Pharmacist ☐ Health Care Provider (HCP)

\*(15) MAP Consultant Contacted: ☐ Yes ☐ No

(15A) First Name:

(15B) Last Name:

\*(16) Date Consultant Contacted:

\*(17) Time Consultant Contacted:

\*(18) Was Medical Intervention Recommended? ☐ YES ☐ NO

(19) If Yes in 18, Check All That Apply:

☐ Lab Work ☐ Other Tests ☐ Health Care Provider (HCP) Visit

☐ Clinic Visit ☐ Emergency Room Visit ☐ Hospitalization

\*(20) Did any of the following situations or conditions result from the medication occurrence (Check All That Apply)?

☐ Illness ☐ Injury ☐ Death

(21) Was DPH Notified? ☐ YES ☐ NO

According to MAP Policy, DPH must be notified if any medical intervention occurred as a result of the medication occurrence. Such medication occurrences are called "HOTLINES". Answering "Yes" to Question # 18 and selecting any of the choices in Question #20 requires that DPH be notified immediately. **Submit "HOTLINES" within 24 hours of discovery.**

(22) Date DPH was Notified:

(23) Time:

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Individual: First Name:

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\*(24) Was an Incident Report Filed as a Result of the Medication Occurrence? ☐ YES ☐ NO

(25) If Yes in 24, Fill in Incident Number, if known:

\*(26) What is the agency's response to prevent this type of occurrence from happening in the future?

Evaluate existing agency policy/ practices

(from Dictionary #3)

(27) Additional Comments (Also use if "Other" is selected in #26):

\*(28) Name of medication(s) as ordered: (29) Dosage: (30) Frequency/Time: (31) Route (Dictionary #4)

			Oral
			Oral
			Oral

\*(32) Name of Medication as Given: (33) Dosage: (34) Frequency/Time: (35) Route (Dictionary #4)

			Oral
			Oral
			Oral

\*(36) Number of medications supposed to be given at same time as the medication occurrence including the medication(s) involved in the medication occurrence (check one): 1

\*(37) Was there a recent change in the medication order for the medication(s) involved in the MOR? ☐ YES ☐ NO

(38) If "Yes" in #37, date of medication order change:

\*(39) Can this medication occurrence be connected to a single staff person? ☐ YES ☐ NO

(40) If Yes in #39, (40A) Staff Person First Name:

OPTIONAL

(40B) Staff Person Last Name:

(41) If Yes in #39, is the staff person a regular staff member? (Select one)

☐ YES ☐ NO, Contracted Relief Staff ☐ NO, Agency Relief Staff(42) If Yes in #39, does this person regularly administer medications as part of their routine responsibility? ☐ YES ☐ NO

(43) Was the person who caused the medication occurrence working their regular shift?

☐ YES ☐ NO – Different Shift ☐ NO – Overtime Shift(44) Was the person who caused the medication occurrence working at their routine site? ☐ YES ☐ NO**SUBMIT MOR TO MAP COORDINATOR WITHIN 7 BUSINESS DAYS OF DISCOVERY**

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Individual: First Name:

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### **MAP COORDINATOR REVIEW**

\*(45) Review Status: ☐ Approved ☐ Not Approved

\*(46) Reason for Non-Approval: ☐ Referred to Provider for follow-up

☐ Other

(47) If "Other" in #46, explain:

(48) Follow-up Date:

(49) Comments/Recommendations: